Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAPTIST ST ANTHONYS HEALTH
PO BOX 1889
AMARILLO TX 79105-1889

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-2370-01

MFDR Date Received
March 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The injured worker] was treated in HCP's emergency room on March 30, 2011 on 9:36 p.m. complaining of back pain and pain radiating down his leg. It was a sharp pain worsened by movement and relieved by nothing. [The injured worker] made the decision to be treated in the emergency room as he could not relieve his pain on his own. He was given IV pain medications. . . . Since he presented in the emergency room preauthorization was impossible."

Amount in Dispute: $2,463.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant admitted himself to the requestor's emergency department on 3/30/11 at 9pm. A CT scan of the low back was done. Medications were given for the claimant's pain. No other testing or treatment was provided. The claimant was discharged home at 1:40am. . . . The documentation does not support a medical emergency."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2011	Outpatient Hospital Services	$2,463.12	$647.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - CAC-B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
    - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
    - 242 – NOT TREATING DOCTOR APPROVED TREATMENT.
    - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
    - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
    - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issues

1. Did the respondent support the insurance carrier's reasons for denial of reimbursement for disputed services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason codes CAC-B7 – "THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE," 242 – "NOT TREATING DOCTOR APPROVED TREATMENT," and 899 – "DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2." 28 Texas Administrative Code §180.22(c)(1) requires that the treating doctor shall, except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee. 28 Texas Administrative Code §133.2(3)(A) defines a medical emergency as "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." The Division notes that it is not required that the patient actually be in jeopardy or suffer serious dysfunction; rather, what is required is that the patient manifest acute symptoms of such severity (including severe pain) that the health care provider, prior to treatment and without the benefit of hindsight, could reasonably expect the patient to be in jeopardy or to suffer serious dysfunction without further attention. Review of the submitted documentation finds that the injured worker presented to the emergency room after 9:00 PM with symptoms of severe back pain running to his leg. The emergency department record documents a score on the pain scale of 10 out of 10. The submitted documentation supports that the injured worker manifested symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious harm or jeopardy to the injured worker. As a medical emergency is supported, the disputed services were not required to be approved by the injured worker's treating doctor. Consequently, the insurance carrier's denial reasons are not supported. These services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are

publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code C1894 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 72131 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. This procedure code may be assigned to composite APC code 8005, for CT services without contrast; however, as no other CT services were provided, the criteria for composite payment are not met for this code. This service is paid separately and is not assigned to a composite APC. This service is classified under APC 0332, which, per OPPS Addendum A, has a payment rate of $193.85. This amount multiplied by 60% yields an unadjusted labor-related amount of $116.31. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $99.26. The non-labor related portion is 40% of the APC rate or $77.54. The sum of the labor and non-labor related amounts is $176.80. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $176.80. This amount multiplied by 200% yields a MAR of $353.60.
- Procedure code 96375 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of $22.13. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $18.89. The non-labor related portion is 40% of the APC rate or $14.75. The sum of the labor and non-labor related amounts is $33.64. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $67.28. This amount multiplied by 200% yields a MAR of $134.56.
- Procedure code 99282 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. This service is classified under APC 0613, which, per OPPS Addendum A, has a payment rate of $87.25. This amount multiplied by 60% yields an unadjusted labor-related amount of $52.35. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $44.68. The non-labor related portion is 40% of the APC rate or $34.90. The sum of the labor and non-labor related amounts is $79.58. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $79.58. This amount multiplied by 200% yields a MAR of $159.16.
- Procedure code 96374 is unbundled. This procedure is a component service of procedure code 99282 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J1200 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1790 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. The total allowable reimbursement for the services in dispute is $647.32. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $647.32. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $647.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $647.32, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 12, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.